



SC Department of Disabilities and Special Needs Medication Error/Event Report

☐ Community ☐ Regional Center

Provider Reporting Incident: _____ County: _____

☐ District I: ☐ Midlands ☐ Piedmont

☐ District II: ☐ Coastal ☐ Pee Dee

Residence of Consumer:

☐ CRCF ☐ CTH I ☐ CTH II ☐ ICF
☐ SLP I ☐ SLP II
☐ Unit @ Regional Center

Descriptive Location of Residence:

(Example: Smith CTH I, Pee Dee Center)

Location of Incident:

☐ CRCF ☐ Day Program
☐ CTH ☐ ICF
☐ SLP ☐ Unit @ Regional Center

Descriptive Location of Incident:

(Indicate unit name in Regional Center, provider operated facility name, i.e., Sunrise CTH II, enclave, work activity center)

Consumer:

First _____

Middle _____

Last _____

DOB:

/ /
MM DD YY

Age:

Sex:

☐ Male
☐ Female

Date of Med Error:

/ /

Time of Med Error:

: ☐ AM ☐ PM

Date Error Found:

/ /

Name & Dose of Medications Involved:

What type of Med Error/Event occurred: (Mark all that Apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Wrong person given the medication | <input type="checkbox"/> Transcription error | <input type="checkbox"/> "Near Miss" for a Med error |
| <input type="checkbox"/> Wrong medication given | <input type="checkbox"/> Medication not signed off on properly | <input type="checkbox"/> Person refused medication |
| <input type="checkbox"/> Wrong dosage given | <input type="checkbox"/> Medication found | (Record attempts/ methods) |
| <input type="checkbox"/> Wrong route of administration | | <input type="checkbox"/> Unsafe circumstances |
| <input type="checkbox"/> Wrong time | | |
| <input type="checkbox"/> Medication not given by staff | | |
| <input type="checkbox"/> Medication given without an order | | |

**What was the result of the Med Error/Event:
(At the time the Report was completed)**

- ☐ No Error (Near Miss or Red Flag Event)
☐ Error, No Reaction
☐ Error, Reaction, No medical Rx required
☐ Error, Reaction, Medical Rx required *
☐ Error, Reaction, Death *

Prescriber Notified: ☐ Yes ☐ No

When: _____

By Whom: _____

If no, explain: _____

Staff Suspected of Making the Error:

Events Leading to Med Error/Event:

Name of Prescriber:

Name of Pharmacy:

Signature of Person Making Out Report/Date

Signature of Supervising Nurse :

Date:

Signature of Program Administrator :

Date:

* Requires the completion of Critical Incident Report per 100-09-DD.